SERFF Tracking Number:	*MGCC-126459883*	*State:*	*Arkansas*
Filing Company:	*The Mega Life and Health Insurance Company*	*State Tracking Number:*	*44724*
Company Tracking Number:	*CIT: NLR 10/03/2009 AR HB 2195*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.001 Any Size Group*
Product Name:	*26025-C (SSMB) AR (01/10)*		
Project Name/Number:	*HB 2195/*		

Filing at a Glance

Company: The Mega Life and Health Insurance Company

Product Name: 26025-C (SSMB) AR (01/10)	SERFF Tr Num: MGCC-126459883	State: Arkansas
TOI: H15G Group Health - Hospital/Surgical/Medical Expense	SERFF Status: Closed-Approved-Closed	State Tr Num: 44724
Sub-TOI: H15G.001 Any Size Group	Co Tr Num: CIT: NLR 10/03/2009 AR HB 2195	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Dianna Cordova, Jaime Butler, Kim Perkins	Disposition Date: 02/03/2010
	Date Submitted: 01/29/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: HB 2195	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 02/03/2010	Explanation for Other Group Market Type:
	State Status Changed: 02/03/2010
Deemer Date:	Created By: Dianna Cordova
Submitted By: Dianna Cordova	Corresponding Filing Tracking Number:

Filing Description:

Please refer to cover letter.

Company and Contact

Filing Contact Information

Dianna Cordova, Compliance Analyst II	dianna.cordova@healthmarkets.com

SERFF Tracking Number:	*MGCC-126459883*	*State:*	*Arkansas*
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9151 Boulevard 26
North Richland Hills, TX 76180

817-255-8283 [Phone]
817-255-8153 [FAX]

Filing Company Information

The Mega Life and Health Insurance Company	CoCode: 97055	State of Domicile: Oklahoma
9151 Boulevard 26	Group Code: 264	Company Type: Health
North Richland Hills, TX 76180	Group Name:	State ID Number:
(817) 255-3100 ext. [Phone]	FEIN Number: 59-2213662	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50.00 POLICY FEE
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Mega Life and Health Insurance Company	$50.00	01/29/2010	33883795

SERFF Tracking Number:	*MGCC-126459883*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/03/2010	02/03/2010

SERFF Tracking Number:	*MGCC-126459883*	*State:*	*Arkansas*
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Project Name/Number:	*HB 2195/*		

Disposition

Disposition Date: 02/03/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MGCC-126459883*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	ARGA 0104	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes

SERFF Tracking Number:	*MGCC-126459883*	*State:*	*Arkansas*
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Project Name/Number:	*HB 2195/*		

Form Schedule

Lead Form Number: 26025-C (SSMB) AR (01/10)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/03/2010	26025-C (SSMB) AR (01/10)	Certificate	Certificate	Initial			26025-C (SSMB) AR (01-10).pdf

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

MEDICAL/SURGICAL EXPENSE INSURANCE CERTIFICATE

IMPORTANT NOTICE ABOUT STATEMENTS IN THE ENROLLMENT APPLICATION

The attached enrollment application is a part of this Certificate. Please read it and check it carefully. This Certificate is issued on the basis that Your answers are correct and complete. If it is not complete or has an error, please let Us know within 10 days. An incorrect enrollment application may cause Your coverage to be voided, or a claim to be reduced or denied.

10 DAY RIGHT TO EXAMINE THE CERTIFICATE

It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Certificate to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Certificate Date, refund all premiums paid and treat the Certificate as if it were never issued.

RENEWABILITY

This Certificate is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of this Certificate. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Certificate may change in amount by reason of an increase in the age of an Insured Person.

NOTICE TO BUYER: This is a medical-surgical expense Certificate. This Certificate provides limited Benefits and should not be considered a substitute for comprehensive health insurance coverage.

This Certificate is a legal contract between You and Us. **PLEASE READ YOUR CERTIFICATE CAREFULLY!**

SECRETARY PRESIDENT

IMPORTANT MESSAGE TO OUR CERTIFICATEHOLDERS

Canceling health insurance coverage and purchasing new coverage, on account of encouragement by any agent, is called replacement. Some states have laws which forbid any misrepresentation by any agent that may occur at the time of replacement. Beware of anyone who encourages You to replace this coverage without allowing You time to carefully investigate the replacement proposal, or discourages You from talking with a representative of the Company whose coverage is being recommended for replacement. For Your protection, if You are encouraged to replace this coverage, We urge You to seek advice and to take the time to investigate any recommendation.

TABLE OF CONTENTS

CERTIFICATE SCHEDULE

COVERAGE IS PROVIDED UNDER GROUP POLICY NO:

ISSUED TO GROUP POLICYHOLDER:

PRIMARY INSURED:

COVERED DEPENDENTS:

CERTIFICATE NUMBER: CERTIFICATE DATE:

INITIAL PREMIUM: MODE OF PAYMENT:

SCHEDULE OF BENEFITS

LIFETIME MAXIMUM AMOUNT:	[$2,000,000]
[AGGREGATE MAXIMUM AMOUNT:	[$1,000,000]**]**
DEDUCTIBLE: **[The Deductible applies to each Insured Person and for each [Sickness or Injury Period of Treatment.] (See page [8] for definition of Deductible.)]**	[$1,000/$2,000/$3,000/$5,000/$7,500]*

*This Deductible amount will be reduced by one-half when Hospital Confined due to an Injury.

BENEFITS	**COINSURANCE/AMOUNT OF BENEFIT**
Inpatient Hospital Services	[70%][80%] of Covered Expenses not to exceed a [$25,000/$40,000/$60,000] Maximum Benefit per Insured Person, per [Sickness or Injury Period of Treatment]
Physician Visits while Hospital Confined (limited to 1 visit per day)	[100%] of Covered Expenses, not to exceed a [$100] Maximum Benefit, per Insured Person, per day
Surgeon Benefit	
When Hospital Confined	[70%][80%] of Covered Expenses not to exceed a [$10,000/$15,000/$25,000] Maximum Benefit, per Insured Person, per Sickness or Injury Period of Treatment
When not Hospital Confined	[70%][80%] of Covered Expenses not to exceed a *{calculation equals 60% of the maximum Surgeon benefit payable when Hospital Confined}* Maximum Benefit, per Insured Person, per [Sickness or Injury Period of Treatment]
Assistant Surgeon Benefit	70%][80%] of Covered Expenses not to exceed [20%] of the surgeon's Covered Expenses
Anesthesiologist Benefit	[70%][80%] of Covered Expenses not to exceed [50%] of the surgeon's Covered Expenses

CERTIFICATE SCHEDULE (Continued)
SCHEDULE OF BENEFITS (Continued)

BENEFITS	COINSURANCE/AMOUNT OF BENEFIT
Outpatient Surgery Facility Charges	[70%][80%] of Covered Expenses not to exceed a *{calculation equals 60% of the Inpatient Hospital Services benefit}* Maximum Benefit, per Insured Person, per [Sickness or Injury Period of Treatment]
Durable Medical Equipment and Prosthetic Devices	[70%][80%] of Covered Expenses not to exceed a [$5,000] Maximum Benefit per Insured Person, per [Sickness or Injury Period of Treatment]
Second Surgical Opinion	[70%][80%]of Covered Expenses
Outpatient Diagnostic Services (incurred within [21] days of a Surgery or Hospital Confinement and related to and necessary for the diagnosis and treatment of the Sickness or Injury that results in Surgery or Hospital Confinement)	[70%][80%] of Covered Expenses up to [$2,000] per Insured Person, per 24 hour period, not to exceed a [$10,000/$15,000/$25,000] *{amount equals maximum Surgeon Benefit payable when Hospital Confined}* Maximum Benefit, per Insured Person, per [Sickness or Injury Period of Treatment]
[Copayment, per Insured Person, per 24 hour period	[$50]]
Ambulance Transport (payable only when Hospital Confined)	[70%][80%] of Covered Expenses not to exceed [$500] Maximum Benefit, per Insured Person, per trip
Chemotherapy	
With approved Chemotherapy or Radiation Therapy Course of Treatment Plan	[70%][80%] of Covered Expenses not to exceed a [$25,000/$40,000/$60,000] Maximum Benefit per Insured Person, per [Sickness or Injury Period of Treatment]
Without approved Chemotherapy or Radiation Therapy Course of Treatment Plan	[70%][80%] of Covered Expenses up to a [$1,500] Maximum Benefit, per Insured Person, per day
Radiation Therapy	
With approved Chemotherapy or Radiation Therapy a Treatment Plan	[70%][80%] of Covered Expenses not to exceed [$25,000/$40,000/$60,000] Maximum Benefit per Insured Person, per Sickness or Injury Period of Treatment
Without approved Chemotherapy or Radiation Therapy Treatment Plan	[70%][80%] of Covered Expenses up to a [$1,250] Maximum Benefit, per Insured Person, per day

CERTIFICATE SCHEDULE (Continued)
SCHEDULE OF BENEFITS (Continued)

BENEFITS	COINSURANCE/AMOUNT OF BENEFIT
Mental Illness and Substance Use Disorders	[70%][80%] of Covered Expenses
Child Health Supervision Services (Not subject to Deductible, Coinsurance or Copayment)	100% of Covered Expenses
Screening Test for Hearing Impairment (Includes diagnostic follow-up care related to screening test from birth through age 24 months; not subject to Deductible or a dollar limit)	[70%][80%] of Covered Expenses
Treatment for Diabetes	[70%][80%] of Covered Expenses
Temporomandibular Joint (TMJ) Includes Medically Necessary diagnostic or surgical treatment	[70%][80%] of Covered Expenses
All Other Covered Expenses shown in the BENEFITS section of this Certificate but not specifically listed in this Schedule of Benefits and not specifically excluded	[70%][80%] of Covered Expenses

CERTIFICATE SCHEDULE (Continued)
SCHEDULE OF BENEFITS (Continued)

RIDER BENEFITS	**Amount of Benefit**
OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY RIDER	[70%][80%]of Covered Expenses
Physical Therapy and Occupational Therapy (Commencing within 14 days of a covered Hospital Confinement or Surgery and rendered in the 90 days) Immediately following the related covered Hospital Confinement or Surgery	Up to [3] visits per Insured Person, per week, not to exceed a [$150] Maximum Benefit, per Insured Person, per day
[Copayment, per visit	[$50]]
Speech Therapy	[70%][80%] of Covered Expenses
OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER	[100%] of Covered Expenses not to exceed a [$500][$1,000][$1,500] Maximum Benefit per Insured Person, per Injury
[Deductible, per Injury	[$50][$100][$150]]
PREGNANCY/CHILDBIRTH BENEFIT RIDER	
Coinsurance	
0-24 months in force	50% of Covered Expenses not to exceed a [$1,000] Maximum Benefit, per In vitro fertilization procedure and/or pregnancy/childbirth for You or Your Covered Dependent Spouse
25 months in force and over	[100%] of Covered Expenses not to exceed a [$2,000] Maximum Benefit, per in vitro fertilization procedure and/or pregnancy/childbirth for You or Your Covered Dependent Spouse
Lifetime Maximum for In Vitro Fertilization Benefits:	[$15, 000]
AIR AMBULANCE RIDER	[70%] [80%] not to exceed a base rate of [$2,500], plus an additional [$50] per mile
Maximum Benefit, per Insured Person, per Calendar Year	[$5,000]

CERTIFICATE SCHEDULE (Continued)
SCHEDULE OF BENEFITS (Continued)

RIDER BENEFITS	Amount of Benefit
CONTINUED CARE BENEFIT RIDER	
Skilled Nursing Care	[70%][80%] of Covered Expenses up to [30 days] per Insured Person, per [Sickness or Injury Period of Treatment] not to exceed a [$250] Maximum Benefit per Insured Person, per day
Home Health Care	[70%][80%] of Covered Expenses not to exceed [80 visits] per Insured Person, per [Sickness or Injury Period of Treatment] not to exceed a [$50] Maximum Benefit per Insured Person, per day
Private Duty Nursing	[70%][80%] of Covered Expenses not to exceed [40 eight-hour shifts] per Insured Person, per [Sickness or Injury Period of Treatment] not to exceed a [$50] Maximum Benefit per Insured Person, per shift
Hospice Care	[70%][80%] of Covered Expenses not to exceed a [$5,000] Maximum Benefit per Insured Person, per lifetime
LEGEND PRESCRIPTION DRUG EXPENSE RIDER	[YES]
[PREVENTIVE PLUS] BENEFIT RIDER	[YES]
MAJOR ILLNESS BENEFIT ENHANCEMENT RIDER	[YES]
MAJOR INJURY [AND ILLNESS] BENEFIT ENHANCEMENT RIDER	[YES]
RETURN OF PREMIUM BENEFIT	[YES]
RATE GUARANTEE RIDER	[YES]
EMERGENCY SERVICES BENEFIT RIDER	[50%][70%][80%][100%] of Covered Expenses [not to exceed a [$15,000] [$24,000] [$36,000] Maximum Benefit per Insured Person, per visit]
[Physician's Office or Urgent Care Center Copayment, per visit]	[$100][$250][$500][$1,000]
[Hospital Emergency Room Copayment, per visit]	[$100][$250][$500][$1,000

DEFINITIONS

Aggregate Maximum Amount means the maximum amount payable under this Certificate and its Riders, if any, for any one covered Injury or Sickness for each Insured Person, occurring while coverage is in effect under this Certificate for such person. Multiple Sickness or Injury Periods of Treatment for the same Sickness or Injury will accumulate toward the Aggregate Maximum Amount. The Aggregate Maximum Amount is shown in the CERTIFICATE SCHEDULE. This amount is included in and part of the Lifetime Maximum Amount for each Insured Person.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Ambulance means a ground vehicle which is licensed as required by law, as an Ambulance, and is equipped to transport Sick or Injured people.

Attained Age means the Insured Person's age on the most recent annual anniversary of the Certificate.

Benefit means the actual amount paid under this Certificate and any attached riders after the application of the Deductible, Coinsurance or Copayments, if any.

Calendar Year means a twelve month period which begins at 12:01 a.m. on January 1 of any year and ends at 12:00 midnight on December 31 of that year.

Certificate means this written description of coverage under the Group Policy, provided to You by Us.

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a Controlled Substance.

Chemical Dependency Treatment Center means a facility that provides a program for the treatment of chemical dependency under a written treatment plan approved and monitored by a physician and that is:

1. Affiliated with a hospital under a contractual agreement with an established system for patient referral;
2. Accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Healthcare Organizations;
3. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by another state agency.

Chemotherapy and Radiation Therapy Course of Treatment Plan means a written plan by the Insured Person’s Physician which indicates but is not limited to:

1. The condition requiring treatment, along with recommended individual protocol; and
2. The anticipated duration of treatment and schedule of services and supplies; and
3. The facility to be used, if any and the name of any other Provider that performs the services.

Class Basis means the classification by which each Insured Person's rates are determined. We will not and cannot change the rates on this Certificate unless rates are changed on all Certificates issued on the same Class Basis.

Cognitive Communication Therapy means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive Rehabilitation Therapy means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Coinsurance means the shared percentage of Covered Expenses after satisfying the Deductible and any Copayments. The Coinsurance percentage We pay is shown in the CERTIFICATE SCHEDULE.

Community Reintegration Services means services that facilitate the continuum of care as an affected individual transitions into the community.

Complications of Pregnancy means:

1. Hospital confinement or treatment in an Outpatient Surgery Facility (when the pregnancy is not terminated) required to treat conditions, such as the following, in a pregnant female Insured Person: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) HELLP syndrome; (e) uterine rupture; (f) amniotic fluid embolism; (g) chorioamnionitis; (h) fatty liver in pregnancy; (i) septic abortion; (j) placenta accreta; (k) gestational hypertension; (l) puerperal sepsis; (m) peripartum cardiomyopathy; (n) cholestasis in pregnancy; (o) thrombocytopenia in pregnancy; (p) placenta previa; (q) placental abruption; (r) acute cholecystitis and pancreatitis in pregnancy; (s) postpartum hemorrhage; (t) septic pelvic thrombophlebitis; (u) retained placenta; (v) venous air embolus associated with pregnancy; (w) miscarriage; or (x) an emergency c-section required because of (i) fetal or maternal distress during labor, or (ii) severe pre-eclampsia, or (iii) arrest of descent or dilatation, or (iv) obstruction of the birth canal by fibroids or ovarian tumors, or (v) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the Insured Person and/or Physician or solely due to a previous c-section.
2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female Insured Person when the condition was caused by, necessary because of, or aggravated by the pregnancy: (a) hyperthyroidism; (b) hepatitis B or C; (c) HIV; (d) Human Papilloma Virus; (e) abnormal PAP; (f) syphillis; (g) chlamydia; (h) herpes; (i) urinary tract infections; (j) thromboembolism; (k) appendicitis; (l) hypothyroidism; (m) pulmonary embolism; (n) sickle cell disease; (o) tuberculosis; (p) migraine headaches; (q) depression; (r) acute myocarditis; (s) asthma; (t) maternal cytomegalovirus; (u) urolithiasis; (v) DVT prophylaxis; (w) ovarian dermoid tumors; (x) biliary atresia and/or cirrhosis; (y) first trimester adnexal mass; (z) hydatidiform mole; or (aa) ectopic pregnancy.

Complications of Pregnancy do not include false labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication.

Confined/Confinement means an Insured Person's Medically Necessary admission to and subsequent continued stay in a Hospital or skilled nursing facility as an overnight bed patient and a charge for room and board is made.

Controlled Substance means a Toxic Inhalant or substance designated as a Controlled Substance in Chapter 481, Health and Safety Code.

Consultation means evaluation, diagnosis, or medical advice given without the necessity of a personal examination or visit.

Copayment means the amount the Insured Person is required to pay for specifically listed Covered Expenses. The Copayment, if any, is shown in the CERTIFICATE SCHEDULE. Copayments do not count toward Deductibles.

Cosmetic Surgery means the surgical procedures for the sole purpose of improvement of appearance, which does not effect a substantial improvement or restoration of bodily function, **except**:

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part, provided the condition which necessitates the Surgery occurs while coverage is in force and remains in force through the Surgery;
2. Reconstructive Surgery in connection with a mastectomy. The reconstructive Surgery will be provided in a manner determined to be appropriate in consultation with the attending Physician and the Insured Person, and will include:
   a. Reconstruction of the breast on which the mastectomy has been performed;
   b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
   c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy;

3. With respect to a Covered Dependent under age 18, reconstructive Surgery for craniofacial abnormalities, to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease; and
4. With respect to a newborn child, reconstructive Surgery to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects.

Covered Dependent means an Eligible Dependent whose coverage has become effective under this Certificate and has not terminated.

Covered Expenses means Usual and Customary Charges for the services, supplies, care or treatment covered under this Certificate which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a Usual and Customary Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

[Any charges in excess of the Maximum Benefit shown in the Certificate Schedule, if any, will not be considered a Covered Expense.]

Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under this Certificate.

Crisis Stabilization Unit means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions. This includes facilities licensed or certified by the American Board of Psychiatry and Neurology.

Deductible means the amount of Covered Expenses that an Insured Person must pay for each [Sickness or Injury Period of Treatment] before Benefits will be paid. Deductible does **not** include non-Covered Expenses [or Copayments]. **The Deductible will be applied separately for each [Sickness or Injury Period of Treatment] for each Insured Person**.

Once this Deductible has been met [3] times in a [Calendar Year] by any or all Insured Persons under Your Certificate, no further Deductibles must be met for the remainder of that [Calendar Year] for any or all Insured Persons under Your Certificate.

If more than one Insured Person in Your family is injured in the same accident, only one Deductible must be satisfied for Covered Expenses associated with that accident.

Dental Care means services, supplies or other care for dental services and procedures involving tooth structures, extractions, gingival tissues, alveolar processes, dental x-rays (for other than an accidental Injury), procedures of dental origin, odontogenic cysts/tumors, or any orthodontic, periodontic, orthognathic treatment regardless of Medical Necessity. Dental care includes services and supplies for maxillary and/or mandibular augmentation/implant procedures to facilitate the use of full or partial dentures, prosthesis, fixed or removable.

Diabetes Equipment and Supplies means equipment and supplies for the treatment of diabetes which is prescribed by a Physician or health care provider who is licensed or certified to treat diabetes, including:

1. Blood glucose monitors, including non-invasive glucose monitors and those designed to be used by or adapted for legally blind individuals;
2. Test strips specified for use with a corresponding glucose monitor;
3. Lancets and lancet devices;
4. Visual reading strips, urine testing strips, and tablets which test for glucose, ketones and protein;
5. Insulin and insulin analog preparations;
6. Injection aids, including devices used to assist with insulin injection and needle-less systems;
7. Insulin syringes;
8. Biohazard disposal containers;
9. Insulin pumps, both external and implantable, and associated appurtenances, which include:
   a. Insulin infusion devices;

b. Batteries;
c. Skin preparation items;
d. Adhesive supplies;
e. Infusion sets;
f. Insulin cartridges;
g. Durable and disposable devices to assist in the injection of insulin; and
h. Other required disposable supplies;

10. Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which will exceed the purchase price of a similar replacement pump;
11. Prescription medications and medications available without a prescription for controlling the blood sugar level;
12. Podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
13. Glucagon emergency kits.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration (FDA), such equipment and supplies will be covered under the Certificate if they are determined to be Medically Necessary and appropriate by a treating Physician or other health care provider who is licensed or certified to treat diabetes through a written order.

All supplies, including medications, and equipment for the control of diabetes will be dispensed as written, including brand name products, unless substitution is approved by the Physician or the health care provider who is licensed or certified to treat diabetes who issues the written order for the supplies or equipment.

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding any program in which the only purpose is weight reduction) which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications.

Effective Date of Coverage means the date coverage becomes effective under this Certificate with respect to a particular Insured Person.

Eligible Dependent means Your lawful spouse and Your unmarried natural and adopted children and step-children who reside in Your home for more than 6 months in a year, who are under 19 years of age (the Limiting Age). The Limiting Age is extended from the child's 19th birthday to the child's [24th] birthday if the child is enrolled as a full-time student and attends classes regularly at an accredited college or university.

Experimental or Investigational Medicine means a drug, device or medical treatment or procedure:

1. If the drug, or device cannot lawfully be marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3. If reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols by the treating facility or the protocols of another facility studying substantially the same drug, device, or medical treatment or procedures; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Group Policyholder means the entity to which the group insurance contract ("Group Policy") is issued.

Heritable Disease means an inherited disease that may result in mental or physical retardation or death.

Hospital means an Institution operated pursuant to its license for the care and treatment of sick and injured persons for which a charge is made that the Insured Person is legally obligated to pay. The institution must:

1. Maintain, either on its premises or in facilities available to the hospital on a contractual or pre-arranged basis, organized facilities for medical, diagnostic and surgical care for sick and injured persons on an inpatient basis;
2. Maintain a staff of one or more duly licensed Physicians;
3. Provide 24-hour nursing care by or under the supervision of a registered graduate professional nurse (R.N.); and
4. Is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

The term "Hospital" does not include:

1. A convalescent, nursing, rest or rehabilitative facility; a home for the aged; or a special ward, floor or other accommodation for convalescent, nursing, rehabilitation, ambulatory or extended care purposes; or hotel units, residential annexes or nurse administered units in or associated with a hospital; or
2. Any military or veteran's hospital, soldier's home or any hospital contracted for or operated by the Federal Government or any agencies thereof for the treatment of members or former members of the Armed Forces, unless the Insured Person is legally required to pay for services in the absence of this insurance coverage.

Immediate Family means the spouse, parent, son, daughter, brother or sister of the Insured Person.

Injury means bodily harm caused by an accident resulting in unforeseen trauma requiring immediate medical attention and is not contributed to, directly or indirectly, by a Sickness. The Injury must occur after the Insured Person's coverage has become effective and while the coverage is in force.

Insured Person means You or a Covered Dependent under this Certificate.

Intensive Care/Cardiac Care Unit means that part of a Hospital which:

1. Is segregated from the rest of the Hospital facilities;
2. Is exclusively reserved for critically ill patients who require audio-visual observation and/or cardiac monitoring as prescribed by the attending Physician; and
3. Provides room and board, specialized registered graduate professional nurses (R.N.), and special life saving equipment and supplies.

Lifetime Maximum Amount means the maximum amount payable under this Certificate and its Riders, if any, for all Covered Expenses combined, for each Insured Person. Any and all Benefit amounts paid by Us will accumulate toward the Lifetime Maximum Amount from the Certificate Date. The Lifetime Maximum Amount is shown in the CERTIFICATE SCHEDULE.

Low Dose Mammography means the X-ray, examination of the breast using equipment dedicated specially for mammography, including the X-ray tube, filter, compression device, screens, films, and cassettes with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Maximum Benefit means the maximum amount payable for a particular Benefit under this Certificate for each Insured Person, after the application of any Deductibles, Copayments and/or Coinsurance. The Maximum Benefit is shown in the CERTIFICATE SCHEDULE.

Medical Emergency means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expensed to result in:

1. Placing the Insured's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Medically Necessary or Medical Necessity means that a service or supply is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

1. It is provided only as a convenience to the Insured Person or provider;
2. It is not appropriate treatment for the Insured Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

*The following definition is hereby added, effective as of **October 3, 2009** or the Insured Person's Effective Date of Coverage, whichever is later:*

Mental Illness and Substance Use Disorders means those illnesses and disorders that are covered by a health benefit plan listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders; including Substance Use Disorders, unless specifically stated otherwise.

Neurobehavioral Testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral Treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive Rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive Therapy means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback Therapy means services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological Testing means an evaluation of the functions of the nervous system.

Neurophysiological Treatment means interventions that focus on the functions of the nervous system.

Neuropsychological Testing means the administration of comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological Treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Outpatient Contraceptive Service means a(n) consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a device intended to prevent conception. This will not include abortifacients or any other drug or device that terminates a pregnancy.

Outpatient Surgery Facility means a licensed or certified public or private medical facility:

1. With an organized staff of Physicians;

2. Which is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. Which does not provide accommodations for overnight stays; and
4. Which provide continuous Physician services and registered professional nursing services whenever a patient is in the facility.

The term "Outpatient Surgery Facility" will include surgical suites, and facilities operated by a Hospital, which provide scheduled, non-emergency outpatient surgical care.

The term "Outpatient Surgery Facility" does not include:

1. Hospital emergency room;
2. Trauma center;
3. Physician's office (except as shown above);
4. Clinic; or
5. Any facility that an Insured Person is admitted to as an overnight bed-patient and charged for room and board.

Physical Therapy means physical or corrective rehabilitation or physical or corrective treatment of any bodily or mental condition of any person by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, and active, passive, and resistive exercise, and shall include evaluation, treatment planning, instruction and consultative services. Physical Therapy does not include spinal manipulations or manipulative therapy.

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license. A member of the Insured Person's Immediate Family will not be considered a Physician (with the exception of dentists providing services which are considered Covered Expenses under this Certificate).

Post-Acute Transition Services means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Pre-Existing Condition means a medical condition, Sickness or Injury not excluded by name or specific description for which:

1. Medical advice, Consultation, or treatment was recommended by or received from a Physician within the two year period before the Effective Date of Coverage; or
2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the two year period before the Effective Date of Coverage.

Pre-Notification of Treatment means a determination by Us that medical care or services proposed to be provided to an Insured Person are Medically Necessary and appropriate.

Psychiatric Day Treatment Facility means a mental health facility which provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program and that is clinically supervised by a Physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Psychophysiological Testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Residential Treatment Center for Children and Adolescents means a child-care Institution that provides residential care and treatment for emotionally and disturbed children and adolescents that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

Series of Treatments, for the purpose of treatment for Chemical Dependency, means a planned, structured and organized program to promote chemical free status which may include different facilities or modalities and is

complete when the Insured Person is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatment or when a person fails to materially comply with the treatment program for a period of thirty (30) days.

The following definition is effective until October 2, 2009:

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1. schizophrenia;
2. paranoid and other psychotic disorders;
3. bipolar disorders (hypomanic, manic, depressive, and mixed);
4. major depressive disorders (single episode or recurrent);
5. schizo-affective disorders (bipolar or depressive);
6. pervasive developmental disorders, including autism;
7. obsessive-compulsive disorders; and
8. depression in children and adolescents.

Sickness or Injury Period of Treatment means a period which begins on the date an Insured Person first incurs Covered Expenses for a Sickness or Injury under this Certificate and ends after 365 days. If the same or related Sickness or Injury continues beyond 365 days, Benefits will renew and a new Sickness or Injury Period of Treatment will begin, which includes a new Deductible. Benefits will continue to accumulate toward the Aggregate Maximum Amount and Lifetime Maximum Amount. A separate Sickness or Injury Period of Treatment and Deductible will apply to each Injury or Sickness.

Sickness means an illness or disease which first manifests itself after the Insured Person's coverage becomes effective and while the coverage is in force. Sickness includes Complications of Pregnancy.

Surgery means:

1. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentation's, endoscopic examinations, and other invasive procedures while an Insured Person is under local or general anesthesia;
2. The correction of fractures and dislocations; and
3. Any of the procedures designated by Current Procedural Terminology codes as Surgery.

Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine Medical Service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. compressed digital interactive video, audio or data transmission;
2. clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Service means a health care service initiated by a Physician or provided by a health professional acting under Physician delegation and supervision for purposes of patient assessment by a health professional, diagnosis or consultation by a Physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. compressed digital interactive video, audio, or data transmission;
2. clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. other technology that facilitates access to health care services or medical specialty expertise.

Total Disability or Totally Disabled means:

1. With respect to You, Your complete inability to perform all of the substantial and material duties and functions of Your occupation and any other gainful occupation in which You earn substantially the same compensation earned prior to disability; and

2. With respect to Your Covered Dependent, Confinement of the Covered Dependent as a bed patient in a Hospital.

Toxic Inhalant means a volatile chemical under Chapter 484, Health and Safety Code, or abusable glue or aerosol paint under Section 485.001, Health and Safety Code.

Treatment Plan means a written plan by the Insured Person's Physician which indicates but is not limited to:

1. The condition requiring treatment, along with recommended procedures and a certification that without such care the Insured Person would require Surgery; and
2. The anticipated duration of treatment and schedule of services and supplies; and
3. The facility to be used, if any and the name of any other Provider that performs the services.

Usual and Customary Charges means charge which is the smallest of:

1. The actual charge;
2. The charge usually made for the Covered Expense by the provider who furnishes it; and
3. The prevailing charge made for a Covered Expense in a geographical area by those of similar professional standing.

Verification of Benefits means a reliable representation by Us to a Physician that We will pay the Physician for proposed medical care or services should the services be provided to the Insured Person for whom they are proposed.

We, Us and Our means The MEGA Life and Health Insurance Company.

You, Your, Yours means the primary insured named in the Certificate Schedule whose coverage has become effective and has not terminated.

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

We require evidence of insurability before coverage is provided. Once We have approved Your enrollment application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the Certificate Date shown in the CERTIFICATE SCHEDULE.

Newborn Children

Your or Your Covered Dependent Spouse's newborn child(ren) will be provided coverage after the Certificate Date from the moment of birth for 90 days. Coverage will include but not be limited to: illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas. Coverage will also include routine nursery care and pediatric charges for a well newborn for up to five (5) full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the newborn, whichever is the lesser period of time. To continue coverage beyond the 90 days, You must send written notice directing Us to add the newborn child(ren). If notice is not received within 90 days the newborn child(ren) may be added in accordance with the Additional Dependents provision. This notice must be received by Us within 90 days of the newborn child's date of birth and must be accompanied by any required premium. A claim form or Hospital bill does not constitute written notice.

Additional Dependents

You may add Eligible Dependents by providing evidence of insurability satisfactory to Us and upon payment of any additional premium, if required.

The acceptance of a new Eligible Dependent and the Effective Date of Coverage for such Eligible Dependent will be shown by endorsement and the date of the endorsement.

Adopted Children

Any minor under Your or Your Covered Dependent Spouse's charge, care and control for whom You or Your Covered Dependent Spouse have filed a petition to adopt, will be provided coverage on the same basis as coverage for other Covered Dependents under the Certificate. This coverage will begin on the date of the filing of a petition; or from the moment of birth, if the petition for adoption and application for coverage is filed within sixty (60) days after the date of birth.

Court Ordered Dependent Child Coverage

A child for whom You or Your Covered Dependent Spouse are required to provide medical support pursuant to a court order will be covered for 31 days from the date We receive a medical support order or notice of a medical support order. Within 31 days after receipt of such court order or notice of such court order, We will complete all necessary forms and procedures to enroll the child under the Certificate for coverage beyond the 31-day period, if We receive:

1. An application for the child by:
   a. You or Your Covered Dependent Spouse;
   b. the custodial parent;
   c. the child support agency having duty to collect or enforce support for the child; or
   d. the child, if he or she is over age 18; and
2. Payment of the required premium, if any, within 31 days of receipt of the medical support order or notice of medical support order. However, We will not terminate the child's coverage if our billing cycle does not coincide with this 31-day premium payment requirement, until the next billing cycle has occurred and there has been nonpayment of the additional required premium, within 30 days of the due date of such premium. Premium for such child's coverage will be the same as all other dependent children covered under the Group Policy.

If the child is not enrolled under the Certificate at the end of the 31-day period, We will report the reasons the child has not been enrolled as may be required by law.

PREMIUMS

Premium Due Date

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, semi-annually or annually, as indicated in the CERTIFICATE SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period. Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

There is a grace period of 31 days for the payment of any premiums due, except the first. At the end of the 31 day grace period, We may cancel the Certificate without further notice. During the grace period, the contract will remain in force; however, the Company is not obligated to pay any claims incurred by Insured Persons during the grace period unless and until the premium due is received during the grace period.

Premium Changes

We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Group Policy at any time and from time to time; provided, We have given the Group Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Certificate may change in amount by reason of an increase in the Attained Age of the Insured Person.

TERMINATION OF COVERAGE

You

Your coverage will terminate and no Benefits will be payable under this Certificate and any attached Riders:

1. At the end of the period for which premium has been paid (subject to the Grace Period);
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date We elect to discontinue this plan or type of coverage. We will give You and the Group Policyholder at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
5. On the date We elect to discontinue all association health benefit plans in Your state. We will give You and the Group Policyholder the proper state authority at least 180 days written notice before the date coverage will be discontinued; or
6. On the date an Insured Person:
   a. performs an act or practice that constitutes fraud; or
   b. has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Certificate, including claims for benefits under the Certificate.

Covered Dependents

Your Covered Dependent's coverage will terminate under this Certificate on:

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent;
3. The date We receive Your written request to terminate a dependent's coverage; or
4. On the date the Covered Dependent:
   a. performs an act or practice that constitutes fraud; or
   b. has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Certificate, including claims for benefits under the Certificate.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof, We may terminate the coverage of such person after the attainment of the Limiting Age.

Family Security Benefit

Beginning with the next premium due date following Our receipt of due proof of Your death, We will waive premiums for a period of 12 months for Your Covered Dependents. During this premium waiver period, no increase in Benefits or addition of Eligible Dependents, except newborns, will be considered. Provisions for termination of coverage for Covered Dependents will also apply. Upon expiration of the 12-month premium waiver period, Your Covered Dependent spouse may continue coverage, as stated in the **Additional Continuation - Provisions for Certain Dependents** section and by making the required premium payments.

Continuation Provision

If the Group Policyholder terminates coverage under the Group Policy, You and Your Covered Dependents may continue Your same (or substantially similar) coverage under this Certificate. To continue coverage, You must continue to pay any required premium.

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Certificate without evidence of insurability if their coverage under this Certificate would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

1. Divorce, legal separation, Your death; or
2. A dependent child reaches the Limiting Age.

In order for Your Covered Dependent to continue coverage, Your or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate, pay any required premium and become a member of the association to which the Group Policy is issued.

Notification Requirements

You or Your Covered Dependent must notify Us in writing within 31 days of the date of any event that would activate the Additional Continuation Provisions for Certain Dependents. Upon our receipt of this notice, written notice will be provided immediately by us to each affected Covered Dependent of the right to continue coverage, with the election form and instructions for premium payment.

Within 60 days of Your death or severance of the family relationship, the Covered Dependent must give us written notice of his or her desire to exercise this continuation option, or the option expires. Coverage remains in effect during the 60-day election period provided the premiums for coverage are paid.

Group Policy

The Group Policyholder may terminate the Group Policy, provided written notice is given at least 31 days prior to the date of termination.

Extension of Benefits

If an Insured Person is Totally Disabled at the time the Group Policy terminates, Benefits will be payable for Covered Expenses incurred due to the Injury or Sickness which caused such Total Disability. Such Benefits are subject to the same terms and conditions of the Group Policy if the Group Policy had remained in force. This extension of Benefits will cease on the earliest of:

1. The date on which the Total Disability ceases; or
2. The end of the 90 day period immediately following the date on which the Insured Person's insurance terminated.

Reinstatement

If coverage under this Certificate terminates due to non-payment of premium, We require an application for reinstatement. The reinstatement will not become effective unless We approved such application. We will advise You of the effective date of reinstatement by giving You written notice of the date, by issuing You an amended Certificate or by issuing You a new Certificate. In any case, the reinstated coverage provides Benefits only for:

1. Injury occurring after the effective date of reinstatement; and
2. Sickness first manifesting itself more than 10 days after the effective date of reinstatement.

CASE MANAGEMENT

Pre-notification Requests of Medical Non-Emergency Admissions

You, Your Physician or Hospital should call the toll-free telephone number shown on Your I.D. card at least 5 working days prior to the planned admission or Surgery. Pre-notification of a Hospital admission or Surgery will enable Us to process claims more expeditiously. The lack of pre-notification will require verification of admission or Surgery through the receipt of actual claims.

For emergency admissions, the patient, patient's representative, Physician or Hospital should call the toll-free telephone number shown on Your I.D. card within 2 working days of the admission, or as soon as reasonably possible, to provide notification of any admission due to a Medical Emergency.

IMPORTANT: Pre-Notification of Treatment is not a Verification of Benefits.

Case Management

Case Management authorized by Us or Our designated representative can provide reimbursement for alternative methods of care, even if the Insured Person is not covered for the alternate care or setting. Case Management is a method where We or Our designated representative will review an Insured Person's health problem and develop a plan of care that provides the most cost effective care for the Insured Person's specialized needs. The intent of Case Management is to ensure appropriate, cost effective care by extending extra-contractual Benefits for alternative methods of care to Insured Persons who require the acute level of care setting. It is not designed to extend extra-contractual Benefits for alternative methods of care to Insured Persons who do not meet Our standards or for services not authorized by Us or Our designated representative.

Benefits will be provided for the approved alternative methods of care only when and for so long as is determined that the alternative services are Medically Necessary and cost effective. These Benefits will count toward the Insured Person's [Aggregate Maximum Amount and] Lifetime Maximum Amount.

Treatment Plans will be used to review and maximize the Benefits available under this Certificate.

Our decision to implement Case Management will be made following Consultation with the affected Insured Person, or his or her legal representative, and the Insured Person's Physician.

If alternative Benefits are provided for an Insured Person in one instance, it will not obligate Us to provide the same or similar Benefits for any person in any other instance; nor will it be construed as a waiver of Our right to administer the Group Policy in strict accordance with its express terms.

Second Physician's Opinion

We or Our designated representative may require an Insured Person to obtain a second opinion with respect to the procedures in question from a Physician selected by Us. The Insured Person must cooperate in obtaining a second opinion including any examination, testing, x-ray, or diagnostic procedures as are reasonable. There is no Coinsurance for the Physician's evaluation for the second opinion, nor for any tests needed to form the second opinion.

Pre-Admission Testing

We or Our designated representative may require that certain testing be done before admission to a Hospital.

BENEFITS

Benefits are the actual amount payable under this Certificate for the following Covered Expenses after application of the following, unless otherwise stated herein:

1. The Maximum Benefit[, Aggregate] and Lifetime Maximum Amounts shown in the CERTIFICATE SCHEDULE;
2. The Deductibles shown in the CERTIFICATE SCHEDULE;
3. The Copayments shown in the CERTIFICATE SCHEDULE, if any;
4. The Coinsurance shown in the CERTIFICATE SCHEDULE;
5. The EXCLUSIONS AND LIMITATIONS; and
6. All other provisions of the Group Policy.

COVERED EXPENSES

Covered Expenses means the Medically Necessary Usual and Customary Charges for the services, supplies, care or treatment covered under this Certificate which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a Usual and Customary Charge which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

[Any charges in excess of the Maximum Benefit shown in the Certificate Schedule, if any, will not be considered a Covered Expense.]

Inpatient Hospital Services

Covered Expenses incurred for services and supplies provided by the Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's intensive care or cardiac care unit (in lieu of Benefit amount payable for Hospital room and board) and miscellaneous medical services and supplies necessary for the treatment of the Insured Person during that Sickness or Injury Period of Treatment.

Covered Expenses will also include x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

Covered Expenses also include charges for anesthesia and Hospital or ambulatory surgical facility charges for services performed in connection with dental procedures, if the treating Physician certifies that due to the patient's age or condition, hospitalization or anesthesia is required to safely and effectively perform the procedure if:

1. A child under 7 years of age who is determined by 2 dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment in a Hospital or ambulatory surgical center for a significantly complex dental condition; or
2. A person with a diagnosed serious mental or physical condition; or
3. A person with a significant behavioral problem as determined by the Insured's Physician licensed under the Arkansas Medical Practice Act.

This law does not apply to coverage for the treatment for temporomandibular joint disorders (TMJ).

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use of the Insured Person while Hospital Confined are not Covered Expenses.

Physician Visits while Hospital Confined

Covered Expenses incurred for visits by a Physician, other than the surgeon, while Hospital Confined, limited to a single Physician visit per day.

Surgeon Benefit

Covered Expenses incurred for services by the Physician performing Surgery.

If two or more Surgeries are performed at the same time through separate incisions, We will consider the one providing the largest Benefit. We will also consider 50% of the Benefits otherwise payable for the other surgeries performed at the same time.

We will not consider more than one Surgery performed through the same incision during the same operation; however, We will consider the Surgery providing the largest Benefit.

If it is recommended that You have Physical Therapy in lieu of Surgery, We may consider Physical Therapy as an alternative to Surgery. Such Physical Therapy must be in accordance with a Treatment Plan approved by Us. Covered Expenses incurred under this Surgeon Benefit for Physical Therapy will be counted toward the applicable Surgeon Benefit shown in the CERTIFICATE SCHEDULE.

Assistant Surgeon Benefit

Covered Expenses incurred for services by the Physician assisting the Physician performing Surgery.

Anesthesiologist Benefit

Covered Expenses incurred for services by the Physician providing anesthesia during Surgery.

Outpatient Surgery Facility Charges

Covered Expenses incurred for services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to:

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery; and
5. General anesthesia and associated Outpatient Surgery Facility Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for which a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

Second Surgical Opinion

Covered Expenses incurred for services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Expense under this Certificate.

If the second opinion disagrees with the first, a third opinion will also be considered a Covered Expense.

Durable Medical Equipment and Prosthetic Devices

Covered Expenses incurred for the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person.

The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person’s coverage is in force.

Routine maintenance and repairs of rental equipment are not Covered Expenses.

Outpatient Diagnostic Services

Covered Expenses incurred within [21] days of a Surgery or Hospital Confinement, for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury that results in Surgery or Hospital Confinement. Covered Expenses include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests. [Please refer to the CASE MANAGEMENT provision shown on page [20] for Pre-Notification Requests of Non-Emergency Admissions.]

Covered Expenses do not include routine physical examinations or checkups.

Ambulance Transport

Covered Expenses incurred for Ambulance transportation to a Hospital, provided the Insured Person is Confined to the Hospital.

Chemotherapy

Covered Expenses incurred for chemotherapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Radiation Therapy

Covered Expenses incurred for radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which radiation therapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Brain Injury

Covered Expenses incurred for services for Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation, Neurobehavioral, Neurophysiological, Neuropsychological, and Psychophysiological Testing or Treatment, Neurofeedback Therapy, remediation, Post-Acute Transition Services or Community Reintegration Services, if such services are Medically Necessary as a result of and related to an Acquired Brain Injury.

Outpatient Contraceptive Services and Devices

Covered Expenses incurred for Outpatient Contraceptive Services and devices, including injectable contraceptives.

Outpatient contraceptive benefits are subject to the same limits, Deductibles, Coinsurance and Copayments as other outpatient benefits under the Certificate, if any.

Administration of Drugs for Covered Chronic, Disabling or Life-Threatening Illnesses

Covered Expenses incurred for the administration of drugs used to treat covered chronic, disabling or life-threatening illnesses when prescription drug coverage is provided by an optional rider.

Mental Illness and Substance Use Disorders

Covered Expenses include charges for the diagnosis and treatment of Mental Illness and Substance Use Disorders to the same extent that are provided for any other Sickness.

Osteoporosis

Covered Expenses incurred for a medically accepted bone mass measurement for the detection of low bone mass and to determine the Insured Person's risk of osteoporosis and associated fractures. This benefit is only available to Insured Person's who meet the following criteria:

1. A post menopausal woman who is not receiving estrogen replacement therapy;
2. An Insured Person with: vertebral abnormalities; primary hyperparathyroidism; or a history of bone fractures; or
3. An Insured Person who is receiving long-term glucocortaid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Telemedicine Medical Service /Telehealth Service Benefit

Covered Expenses incurred for services provided through a Telemedicine Medical Service or Telehealth Service, as defined, on the same basis as those services provided through a face-to-face consultation.

Temporomandibular Joint (TMJ)

Covered Expenses incurred for Medically Necessary diagnostic or surgical treatment of the temporomandibular joint, including the jaw and craniomandibular joint, that results from an accident, trauma, congenital or developmental defect or pathology.

Minimum Stay Requirements for Mastectomy and Lymph Node Dissection

Covered Expenses incurred for inpatient care if an Insured Person undergoes a covered mastectomy, for a minimum of the following:

1. 48 hours following a covered mastectomy; or
2. 24 hours following a covered lymph node dissection for the treatment of breast cancer.

A shorter period of Confinement will be covered if the Insured Person and her Physician determine that a shorter period of inpatient Hospital Confinement is appropriate.

Screening Test for Human Papillomavirus and Cervical Cancer

Covered Expenses incurred for the following annual screenings, as approved by the United States Food and Drug Administration:

1. A conventional Pap smear screening or a screening using liquid-based cytology methods; or
2. A conventional Pap smear screening in combination with a test for the detection of the Human Papillomavirus.

The screening test required under this benefit must be performed in accordance with the guidelines adopted by:

1. The American College of Obstetricians and Gynecologists; or
2. Another similar national organization of medical professionals recognized by the Commissioner.

Mammography

Covered Expenses incurred for an annual Low Dose Mammography screening for each female Insured Person age 35 or older.

Treatment for Diabetes

Coverage will be provided for Diabetes Self-Management Training, Diabetes Equipment and Supplies, and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider.

Child Health Supervision Services

Covered Expenses include charges for each Covered Dependent from the moment of birth to age (18) years. In keeping with prevailing medical standards, such services shall include:

1. Anticipatory guidance;
2. Developmental assessment;
3. Laboratory Tests;
4. Appropriate immunizations;
5. A medical history; and
6. Physical examination.

Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth, two weeks, two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years.

Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas. Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

Heritable Disease

Covered Expenses incurred for special dietary treatment of an Insured Person for a Heritable Disease when recommended and prescribed by a Physician.

Screening Test for Hearing Impairment

Covered Expenses incurred for a screening test of hearing loss for a Covered Dependent child from birth through the date the child is 30 days old. Coverage also includes the necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. This benefit is not subject to the Deductible or any dollar limit.

Colorectal Cancer Screening

Covered Expenses include charges for colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at High Risk for Colorectal Cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician.

For the purpose of this benefit, "High Risk for Colorectal Cancer" means: individuals over 50 years of age or who face a High Risk for Colorectal Cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

Medical Foods and Low Protein Modified Food Products

Covered Expenses include charges for the treatment of a Covered Dependent inflicted with phenylketonuria if:

1. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemia and disorders of amino acid metabolism;

2. The products are administered under the direction of a licensed Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the two thousand four hundred dollars ($2,400) per year per person income tax credit allowed.

*The following benefit is effective as of **July 31, 2009** or the Insured Person's Effective Date of Coverage, whichever is later:*

Orthotics and Prosthetics

Covered Expenses include charges for orthotic and prosthetic devices and services, including repairs and replacements due to anatomical change or normal use. Such devices and services must be prescribed by a licensed doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine and provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, an orthotics, or a prosthetics licensed by the State of Arkansas. The reimbursement amount shall be at the minimum of eighty percent of Medicare allowables as defined by the Center for Medicare Medicaid Services, Healthcare Common Procedure Coding System for:

1. An orthotic device;
2. An orthotic service;
3. A prosthetic device; and
4. A prosthetic service.

For the purpose of this benefit, "Orthotic Device" means an external device that is custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

Orthotic Device does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that: (i) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and (ii) has no significant impact on the neuromuscular, musculosketetal, or neuromusculoskeletal functions of the body.

For the purpose of this benefit, "Prosthetic Devices" means an external device that is intended to replace an absent external body part and custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

Prosthetic Device does not include an artificial eye, an artificial ear, a dental appliance, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, and artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

*The following benefit is effective **until December 31, 2009:***

Prostate Cancer Screening

Covered Expenses incurred for the following services and supplies provided to an Insured Person for the detection of prostate cancer:

1. an annual physical examination for the detection of prostate cancer for each male Insured Person; and
2. an annual prostate-specific antigen (PSA) test used for the detection of prostate cancer for each male Insured Person who is:
   (a) at least 50 years of age and asymptomatic; or
   (b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

*The following benefit is effective as of **January 1, 2010** or the Insured Person's Effective Date of Coverage, whichever is later:*

Prostate Cancer Screening

Covered Expenses include a screening for the early detection of prostate cancer for a male Insured Person 40 years of age and older, as according to the National Comprehensive Cancer Network guidelines.

The screening shall consist of the following tests:

1. Annual prostate specific antigen test (PSA); and
2. Digital rectal exam (DRE).

[This benefit is not subject to a Deductible.]

Impairment or Loss of Speech or Hearing

Covered Expenses include the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

Complications of Pregnancy

Covered Expenses incurred for the treatment of Complications of Pregnancy while Hospital Confined or in an Outpatient Surgery Facility (when the pregnancy is not terminated), on the same basis as any other Sickness.

EXCLUSIONS AND LIMITATIONS

We will not provide any Benefits for charges resulting from or in connection with:

1. Any care not Medically Necessary or charges for which Benefits are not specifically provided for in this Certificate;
2. Any act of war, declared or undeclared;
3. Suicide, attempted suicide, or any intentionally self-inflicted Injury, while sane or insane;
4. Any routine physical examination, unless otherwise stated herein;
5. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;
6. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; [(b) in-vitro fertilization or other treatment for infertility;] (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated herein;
7. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
8. Spinal manipulations and manual manipulative treatment or therapy;
9. Mandibular or maxillofacial Surgery to correct growth defects after one year from the date of birth, jaw disproportions or malocclusions, or to increase vertical dimension or reconstruct occlusion, except for the Medically Necessary diagnostic or surgical treatment of the temporomandibular joint, including the jaw and craniomandibular joint, that results from an accident, trauma, congenital or developmental defect or a pathology;
10. Weight loss or modification, or complications arising therefrom, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
11. Breast reduction or augmentation unless necessary in connection with breast reconstructive Surgery following a mastectomy;

12. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
13. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
14. Routine newborn care, unless otherwise stated herein;
15. Directly or indirectly engaging in an illegal occupation or illegal activity;
16. Care in a nursing home, custodial institution or domiciliary care or rest cures;
17. Preparation and presentation of medical reports for appearance at trials or hearings;
18. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded;
19. Immunizations required for the sole purpose of travel outside of the U.S.A.;
20. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
21. Experimental medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
22. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
23. Cosmetic Surgery, unless otherwise stated herein;
24. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Certificate. (The expense must be incurred within one year from the date of Injury, and while Hospital Confined or in an Outpatient Surgery Facility);
25. Corrective vision [or hearing] supplies or for the examination for prescribing or fitting such supplies;
26. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
27. Expenses incurred for prescription drugs, including contraceptives, except if added by Rider;
28. Normal pregnancy, except for Complications of Pregnancy, except Benefits added by Rider, if any; and
29. Treatment, services or supplies received outside the U.S. or Canada. However, Benefits will be payable for Covered Expenses incurred as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada. In no event will Benefits be payable beyond the first 30 days of travel outside of the U.S. or Canada.

Sickness Exclusion

We will not provide Benefits for any loss resulting from a Sickness, as defined, which first manifests itself within the 30 days after the Insured Person's Effective Date of Coverage, until such coverage has been in force for a period of 12 months. However, if an Insured Person had Prior Coverage in force prior to their Effective Date of Coverage under this Certificate, without a break in coverage of more than 30 days, this Sickness Exclusion will be waived.

For the purpose of this provision, 'Prior Coverage' means accident and sickness insurance that would have otherwise covered the Sickness.

Pre-Existing Condition

We will not provide Benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Effective Date of Coverage for an Insured Person.

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person becomes covered under Medicare, the benefits of this Certificate and its attachments, if any, are payable only to the extent that Covered Expenses are not paid by Medicare and they would otherwise be payable under this Certificate. The benefits will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in this Certificate.

COORDINATION OF BENEFITS

All of the benefits provided under the Group Policy are subject to this provision. However, Coordination of Benefits (COB) may not be applied to group Hospital Indemnity Plans of $100 or less, nor to claims of less than

$50.00. If additional liability is incurred to raise the small claim above $50.00, the entire liability may be included in the COB computation.

Plan means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental Plan, or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

This Plan is the part of the group contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan means the order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Allowable Expense means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.

Claim Determination Period means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

When there is a basis for claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan unless:

1. The other Plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules, as set forth in the Order of Benefit Determination Rules below, require that This Plan's benefits be determined before those of the other Plan.

Order of Benefit Determination Rules

If this COB provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

1. Shall not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but
2. May be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent. There is one exception. If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.
2. Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph 3.(b) below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
   (a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
   (b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. Dependent Child/Parents Separated or Divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   (a) First, the Plan of the parent with custody of the child;
   (b) Then, the Plan of the spouse of the parent with custody of the child; and
   (c) Finally, the Plan of the parent not having custody of the child.
   (d) However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of the parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
   (e) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph (2) above.

4. Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule (4) is ignored.

5. Continuation Coverage. If an Insured Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
   (a) First, the benefits of a Plan covering the Insured Person as an employee, member or subscriber (or as that Insured Persons dependent);
   (b) Second, the benefits under the continuation coverage.
   If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. No previously listed rules described above applicable. The benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter term.
   (a) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second Plan within 24 hours after the first Plan ended.
   (b) The start of a new Plan does not include:
      (i) a change in the amount or scope of a Plan's benefits;
      (ii) a change in the entity which pays, provides or administers the Plan's benefits; or
      (iii) a change from one type of Plan to another (such as from a single employer Plan to that of a multiple employer Plan).
   (c) The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

Effect on the Benefits of This Plan

1. When this Section Applies. This Section applies when, in accordance with the "Order of Benefit Determination Rules", This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2.(b) immediately below.
2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:
   (a) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
   (b) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with purpose like that of this COB provision, whether or not a claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We way recover the excess from one or more of:

1. The persons we have paid or for whom We have paid
2. Insurance companies; or
3. Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

1. The Group Policy, which includes this Certificate;
2. The application of the Group Policyholder, which will be attached to the Group Policy;
3. Any enrollment applications for the proposed insured individuals; and
4. Any endorsements, amendments or riders attached.

All statements made by the Group Policyholder or by You will, in the absence of fraud, be deemed representations and not warranties.

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend the Group Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Group Policy. Any change in the Group Policy will be made by an amendment approved by the Group Policyholder and signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

Written notice of claim must be given to Us within 20 days, or as soon as reasonably possible. Written notice of claim given by or on behalf of the Insured Person to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms

When We receive the notice of claim, We will send the Insured Person forms for filing proof of loss. If these forms are not furnished within 15 days, the Insured Person will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the next provision.

Proof of Loss

Written proof of loss must be furnished to Us at Our administrative office in North Richland Hills, Texas, within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required.

Claim Payments

We will pay all Benefits due under the Group Policy promptly upon receipt of due proof of loss.

All Benefits are payable to You, however, at Our option, We may pay the provider of service instead, unless You have requested otherwise in writing prior to providing proof of loss. If any such Benefits remain unpaid at Your death, or if You are, in Our opinion, incapable of giving a legally binding receipt for payment of any Benefit, We may, at Our option, pay such Benefit to Your estate or any one or more of the following relatives: Your spouse; mother, father, child or children; brother or brothers; sister or sisters. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

Physical Examination

We will, at Our own expense, have the right and opportunity to examine the Insured Person whose Injury or Sickness is the basis of a claim when and as often as We may reasonably require during the pendency of a claim and to make an autopsy in case of death, unless prohibited by law.

Legal Action

No action at law or in equity will be brought to recover on the Group Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Group Policy; nor may any action be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Age Misstatement

If the age of any Insured Person has been misstated, Our records will be changed to show the correct age. The Benefits provided will not be affected if the Insured Person continues to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due to Us because of past underpayments, will be made so that We receive the premiums due at the correct age payable on the premium due date following Our notification of an age correction.

Incontestability

After 2 years from the Insured Person's Effective Date of Coverage, no misstatements, except fraudulent misstatements, made in the enrollment application will be used to void the coverage, or deny a claim unless the loss was incurred during the first 2 years following such Insured Person's Effective Date of Coverage.

No claim for a loss incurred one year after an Insured Person's Effective Date of Coverage will be reduced or denied as a Pre-Existing Condition.

Conformity

Any provision of this Certificate which, on the Effective Date of Coverage, is in conflict with the extraterritorial statutes of the state in which You reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

Change of Residence

If You move, You must notify the Company. Only the extraterritorial benefits mandated by the State in which You reside will be considered Covered Expenses under this Certificate.

Subrogation

You agree that We shall be subrogated to Your right to damages, to the extent of the Benefits provided by the Certificate, for Injury or Sickness that a third party is liable for or causes. You agree to repay Us first out of any monies You obtain regardless of the amount that You recover. In the event that We retain Our own attorney to represent Our subrogation interest, We will not be responsible for paying a portion of Your attorney fees or costs.

You assign to Us Your claim against a liable party to the extent of Our payments, and shall not prejudice Our subrogation rights. Entering into a settlement or compromise arrangement with a third party without Our prior written consent shall be deemed to prejudice Our rights. You shall promptly advise Us in writing whenever a claim against another party is made and shall further provide to Us such additional information as is reasonably requested by Us. You agree to fully cooperate in protecting Our rights against a third party.

Right of Reimbursement

You may receive Benefits under the Group Policy, and may also recover losses from another source, including Workers' Compensation, uninsured, underinsured, no-fault or personal injury protection coverages. The recovery may be in the form of a settlement, judgment, or other payment.

You must reimburse Us from these recoveries in an amount up to the Benefits paid by Us under the Group Policy. You agree to repay Us first out of any monies You obtain regardless of the amount that You recover. We have an automatic lien on any recovery.

SERFF Tracking Number:	*MGCC-126459883*	*State:*	*Arkansas*
Filing Company:	*The Mega Life and Health Insurance Company*	*State Tracking Number:*	*44724*
Company Tracking Number:	*CIT: NLR 10/03/2009 AR HB 2195*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.001 Any Size Group*
Product Name:	*26025-C (SSMB) AR (01/10)*		
Project Name/Number:	*HB 2195/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/03/2010

Comments:

Attachment:

Readability.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/03/2010

Bypass Reason: Application to be used with this certificate is form 25098-APP (9/99), previously approved by the Department effective October 6, 1999.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Certification/Notice	Approved-Closed	02/03/2010

Comments:

Attachment:

Cert of Compliance Rule-Reg19 -AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	ARGA 0104	Approved-Closed	02/03/2010

Comments:

Attachment:

ARGA 0104.pdf

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	02/03/2010

SERFF Tracking Number:	*MGCC-126459883*	*State:*	*Arkansas*
Filing Company:	*The Mega Life and Health Insurance Company*	*State Tracking Number:*	*44724*
Company Tracking Number:	*CIT: NLR 10/03/2009 AR HB 2195*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.001 Any Size Group*
Product Name:	*26025-C (SSMB) AR (01/10)*		
Project Name/Number:	*HB 2195/*		

Comments:

Attachment:

HB 2195 Cover letter.pdf

The MEGA Life and Health Insurance Company

FLESCH READABILITY CERTIFICATE
State of Arkansas

Form Number	Flesch Score
26025-C (SSMB) AR (01/10)	55.84

I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations in the state of Arkansas.

Susan Dew
Senior VP, Associate General Counsel and Chief Compliance Officer

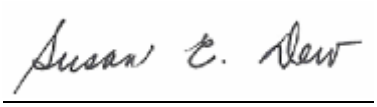
January 18, 2010
DATE

Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: The MEGA Life and Health Insurance Company

Form Number(s): 26025-C (SSMB) AR (01/10)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Susan Dew
Name

Senior VP, Associate General Counsel and Chief Compliance Officer
Title

January 18, 2010
Date

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract..

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

The Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and they hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies or contracts are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws or another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to suture assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administra6tion of a policy by a group contract holder;
- Employers' plans, to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders , not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of any unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments r4equired by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits for net cash surrender values – again, no matter how many policies and contracts there were wit hteh same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets if the impaired or insolvent insurer.]

The MEGA Life and Health Insurance Company
Home Office: Oklahoma City, OK

9151 Boulevard 26
North Richland Hills, TX 76180

January 18, 2010

Arkansas Insurance Department
Commissioner Jay Bradford
Life and Health Division
1200 W 3rd Street
Little Rock, AR 72201-1904
Attn.: Life & Health Division, A&H Form Filing Section

RE: SERFF Tracking Number: MGCC-126459883
The MEGA Life and Health Insurance Company
NAIC#: 264-97055 / FEIN#: 59-2213662

FORM	**DESCRIPTION**
26025-C (SSMB) AR (01/10)	Medical/Surgical Expense Insurance Certificate

Dear Commissioner Bradford:

The above referenced form is submitted for your review and approval. Certificate form 26025-C (SSMB) AR (01/10) has been revised in order to reflect compliance with the requirements of House Bill 2195 regarding Mental Health Parity Act. This revised certificate is intended to replace the previously approved form, 26025-C (SSMB) (approved on June 12, 2006 under SERRF Tracking #: USPH-6M2TDF190/00).

To the best of our knowledge, information and belief, the form submitted herewith is in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

If you have any questions or if anything further is needed to expedite the review of this filing, please call me collect at (817) 255-8283. Your assistance in this matter is greatly appreciated.

Sincerely,

Dianna Cordova
Compliance Analyst II
Dianna.cordova@healthmarkets.com